No. 18-96

In the Supreme Court of the United States

TENNESSEE WINE AND SPIRITS RETAILERS ASSOCIATION,
Petitioner,

v.

ZACKARY W. BLAIR, INTERIM DIRECTOR OF THE TENNESSEE ALCOHOLIC BEVERAGE COMMISSION, ET AL.,
Respondents.

On Writ of Certiorari to the United States Court of Appeals for the Sixth Circuit

AMICI CURIAE BRIEF OF THE U.S. ALCOHOL POLICY ALLIANCE AND PUBLIC HEALTH RESEARCHERS AND ADVOCATES IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

Amicus Curiae U.S. Alcohol Policy Alliance is a nonpartisan, nonprofit group of organizations governed by a board of directors, and guided by an expert advisory board, that translates alcohol policy research into public health practice to prevent and reduce alcohol-related harm in the United States.

Likewise, the *Amici* signatories are organizations comprised of public-health researchers, practitioners, and advocates devoted to studying alcohol regulations, promoting evidence-based reforms, and informing the public about the dangers of excessive alcohol and other drug consumption. "Public health" is the art and science of preventing disease, prolonging life and promoting health through the organized efforts of society. Public health considerations have played a leading role in this country's long-running debate about how best to regulate alcohol. Accordingly, the perspective of those who work in this field is useful to a full understanding of what regulatory responses are effective and the likely consequences of their roll-back.

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[1] Consistent with Sup. Ct. R. 37.6, *amici curiae* and their counsel state that no counsel for any party authored this brief in whole or in part. No party or party's counsel contributed money for the preparation or submission of this brief. No person other than *amici* contributed money that was intended to fund the preparation or submission of this brief. *Amici curiae* file this brief consistent with the blanket consents given by the parties, copies of which are on file in the Clerk's office.

SUMMARY OF ARGUMENT

Through the experiment with Prohibition and later Repeal, a national consensus emerged that alcohol, unlike most other consumer products, could not be left to the ordinary rules of the marketplace without triggering a host of public health harms, from death and injury associated with excessive drinking, to increased crime, violence, poverty, and other forms of social destabilization. The country's experience with the cheap and widely available alcohol that marked the pre-Prohibition era demonstrated that allowing alcohol suppliers and retailers to engage in the usual free market tactics for pumping up sales was an invitation to serious public health and criminal justice problems.

But Prohibition failed in part because its one-size-fits-all approach was too inflexible to accommodate local variations in how people viewed alcohol and how they used or misused it. In response, the Twenty-first Amendment lodged in the states the primary power to regulate alcohol according to the particular circumstances existing within their jurisdictions. The goal, post-Prohibition, was less about encouraging abstinence and more about minimizing excessive drinking and its associated harms through reasonable regulations.

States set about the task of erecting comprehensive regulatory systems responsive to the needs of their citizens. Public health research has shown that many of these regulations are effective at curbing excessive drinking, including binge drinking, which is far and away the greatest source of alcohol-related harms and the one that imposes the greatest monetary costs on society.

Indeed, the public health evidence is conclusive that regulations that restrict access to and the *availability* of alcohol reduce consumption, which in turn reduces the incidence of adverse health consequences and other deleterious effects. Durational residency requirements like Tennessee's help to moderate the flow of alcohol by limiting the leverage of chain retailers—such as grocery stores, convenience stores, and gas stations—on the alcohol market. Chain outlets often have longer hours and days of operation than their non-chain competitors, and they also have a greater capacity to offer price advantages. As a result, public health research shows that when chain retailers are authorized to sell liquor, its overall availability increases as does consumption and alcohol-related health and social harms.

Tennessee's durational residency requirement addresses another problem, and one that especially bedeviled the country in the pre-Prohibition era: It ensures that retailers have a connection to the communities in which they do business and thus have a greater incentive than out-of-state retailers to be viewed as law-abiding, responsible sales people by their neighbors and friends. Before Prohibition, retailers were often owned or dominated by out-of-state interests that had little reason to care how alcohol affected the communities in which they sold it. Tennessee's durational residency requirement maintains that personalized link between sellers and their patrons and communities.

Although the public health literature has not specifically examined Tennessee's durational residency requirement, it has assessed the state's overall alcohol

control structure. Researchers have concluded that Tennessee's regulatory structure is among the *top three highest scoring* in the country, and its rate of binge drinking—which is necessarily influenced by the state's mix of alcohol policies—is the *lowest* in the country. Tennessee thus appears to be more effective than many of its sister states in striking the appropriate regulatory balance.

Courts and opponents of existing regulations sometimes argue that purportedly objectionable regulations can be replaced by other, hypothetical ones that will serve the same purpose. That, however, is rarely, if ever, true. Each state's alcohol control policies together comprise an edifice in which the various regulations support and reinforce one another. Just as removing a brick or two weakens any structure, the same is true of expunging a particular regulation from a state's overall alcohol control system. When that happens, adverse public health consequences are often not far behind.

In sum, if alcohol is viewed solely through the prism of economics, then a vital consideration—that of alcohol's impact on the public's health—risks being overlooked to our collective detriment. Indeed, it was the public health ramifications of alcohol that propelled the drive to Prohibition, animated policymaking post-Repeal, and remain no less relevant and urgent today.

ARGUMENT

A. Cheap and Plentiful Alcohol in the Early Twentieth Century Caused Numerous Public-Health Problems, Ultimately Fueling the Drive Toward Prohibition.

In the years immediately preceding Prohibition, alcohol consumption in the United States was on the rise. Between 1900 and 1913, beer production nearly doubled, from 1.2 billion to 2 billion gallons, and the volume of spirits on which taxes were paid grew from 97 million to 147 million gallons.[2] In that same timeframe (i.e., 1900 to 1913), the amount of alcohol consumed per capita increased nearly 33 percent, a substantial rise in a short period of time.[3] This created serious public health problems.[4] For instance, the rates of death attributable to liver cirrhosis (15 per 100,000 total population) and chronic alcoholism (10 per 100,000 adult population) were high during this period.[5]

The explosive growth in alcohol consumption that characterized the early twentieth century was due in

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[2] Jack S. Blocker Jr., *Did Prohibition Really Work? Alcohol Prohibition as a Public Health Innovation*, 96 AM. J. OF PUB. HEALTH 233-243 (2010).

[3] *Id.* at 235.

[4] *Id.*

[5] Angela K. Dills and Jeffrey A. Miron, *Alcohol Prohibition and Cirrhosis*, 6 AM. L. AND ECON. REV. 285-318 (2004); E. M. Jellinek, *Recent Trends in Alcoholism and in Alcohol Consumption*, 8 QUARTERLY J. OF STUDIES ON ALCOHOL 40 (1947).

no small part to the vertical integration of the industry: Suppliers often owned the retail establishments at which their alcohol was sold, and short of that, they wielded enormous power over the retailers through the use of financial inducements, such as the extension of credit.[6] Through these "tied house" arrangements, out-of-state suppliers drove their retailers to sell as much alcohol as possible.[7] This resulted in "aggressive marketing practices that were beyond the control of local communities."[8] The American saloon, with its steady flow of cheap alcohol, exemplified the problems associated with vertical integration. Indeed, the saloon came to be associated with "political corruption, prostitution, gambling, crime, poverty and family destruction."[9] Against this backdrop, cultural and legal norms became inhospitable to the drinking of alcohol, and the 18th Amendment was passed.

Prohibition was successful in reducing alcohol-related morbidity and mortality. Death rates from cirrhosis and alcoholism, alcoholic psychosis hospital admissions, and drunkenness arrests all declined

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[6] Carole L. Jurkiewicz & Murphy J. Painter, *Why We Control Alcohol the Way We Do, in* SOCIAL AND ECONOMIC CONTROL OF ALCOHOL: THE 21ST AMENDMENT IN THE 21ST CENTURY 1, 6-7 (Carole L. Jurkiewicz & Murphy J. Painter eds., 2008).

[7] *Id.* at 7.

[8] Elyse Grossman & James F. Mosher, *Public Health, State Alcohol Pricing Policies, and the Dismantling of the 21st Amendment: A Legal Analysis*, 15 MICH. ST. U. J. MED. & L. 177, 178 (2011).

[9] W.J. Rorabaugh, *The Origins of the Washington State Liquor Control Board, 1934*, PACIFIC NORTHWEST QUARTERLY (Fall 2009).

steeply during the latter years of the 1910s through the early years after Prohibition went into effect. Even after Repeal, per capita annual consumption stood at 1.2 gallons, less than half the level of the pre-Prohibition period.[10]

However, Prohibition ultimately failed from an enforcement perspective. It was too severe, too inflexible, and failed to consider individual states and their differences.[11] The lesson of Prohibition was that the public's "appetite for liquor could not be completely removed, but only controlled."[12]

The Twenty-first Amendment endeavored to minimize alcohol-related harms by delegating primary regulatory powers to the states, since they were more attuned to the specific problems that alcohol misuse engendered within their borders and could be more nimble in responding to them than the federal government.[13] As policymakers set about the task of mapping out new state-based regulatory systems, they were determined to avoid the evils of "stimulated sales"

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[10] Jeffrey A. Miron and Jeffrey Zwiebel, *Alcohol Consumption During Prohibition*, 81 AMERICAN ECONOMIC REVIEW 242-47 (1991); Dills and Miron, *supra* note 5; Blocker, *"Did Prohibition Really Work? Alcohol Prohibition as a Public Health Innovation," supra* note 2, at 237.

[11] RAYMOND B. FOSDICK & ALBERT L. SCOTT, TOWARD LIQUOR CONTROL 6-7 (The Center for Alcohol Policy 2011) (1933).

[12] Steven Diamond, *The Repeal Program, in* SOCIAL AND ECONOMIC CONTROL OF ALCOHOL: THE 21ST AMENDMENT IN THE 21ST CENTURY 97, 106 (Carole L. Jurkiewicz & Murphy J. Painter eds., 2008).

[13] FOSDICK & SCOTT, *supra* note 11, at 6-8.

that had been the backbone of the saloon.[14] To that end, the states adopted the "three-tier system" in which they walled off suppliers from retailers in part by inserting wholesalers between them. Each tier is separately licensed and regulated, thus precluding vertical integration.[15] Further, the objective of regulation was to allow industry to earn profits, but to prevent it from engaging in competitive practices that could unduly drive up demand, thereby increasing consumption and adverse social consequences.[16]

B. Although Alcohol-Related Harms Are Not Present at the Alarming Rates That Characterized the Years Before Prohibition, They Remain a Serious Public Health Problem.

As it has throughout our history, the misuse of alcohol and the social ills it spawns remains a considerable challenge and one that imposes substantial costs on governments and taxpayers. The following data paint a picture of the nature and magnitude of the problem:

- Excessive alcohol consumption is responsible for approximately 88,000 deaths annually in the

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[14] *Id.* at 10.

[15] Jurkiewicz & Painter, *supra* note 6, at 7; NABCA RESEARCH, THE THREE-TIER SYSTEM: A MODERN VIEW (2015), *available at* https://www.nabca.org/sites/default/files/assets/files/ThreeTierSystem_Mar2015.pdf.

[16] Jurkiewicz & Painter, *supra* note 6, at 7; FOSDICK & SCOTT, *supra* note 11, at 10.

United States, making it the third leading preventable cause of death, after tobacco and poor diet and lack of physical activity.[17]

- In 2010, alcohol misuse cost the United States $249 billion, with three-quarters of that cost related to binge drinking.[18]
- In 2017, 26.4 percent of people 18 and older reported that they engaged in binge drinking in the past month (binge drinking is defined as a blood alcohol concentration of 0.08 g/dL, which typically occurs after four drinks for women and five drinks for men in about two hours).[19]
- About nine in ten excessive drinkers are not addicted to alcohol. In fact, binge drinking is the most common and most dangerous form of

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[17] National Institute on Alcohol Abuse and Alcoholism, *Alcohol Facts and Statistics* (2018), https://pubs.niaaa.nih.gov/publications/AlcoholFacts&Stats/AlcoholFacts&Stats.pdf; Mandy Stahre, et al., *Contribution of Excessive Alcohol Consumption to Deaths and Years of Potential Life Lost in the United States* (June 26, 2014), https://www.cdc.gov/pcd/issues/2014/13_0293.htm.

[18] *Alcohol Facts and Statistics*, *supra* note 17.

[19] Center for Behavioral Health Statistics and Quality, *Results from the 2017 National Survey on Drug Use and Health: Detailed Tables*, Table 2.6B, https://www.samhsa.gov/data/sites/default/files/cbhsq-reports/NSDUHDetailedTabs2017/NSDUHDetailedTabs2017.pdf.

excessive drinking, and is responsible for more than half of deaths.[20]

- In 2014, 31 percent of driving fatalities were attributable to alcohol impairment.[21]
- Excessive drinking is responsible for more than 4,300 deaths among underage youth each year.[22]

C. Public-Health Research Shows That Curbing Excessive Alcohol Consumption Requires a Comprehensive Approach That Incorporates a Variety of Regulatory Tools.

A robust body of public health research shows that combating alcohol misuse requires a comprehensive approach that takes into account society as a whole and the array of environmental conditions and stimuli that can lead to excessive drinking.[23] Focusing narrowly on alcoholics or other high-risk groups is insufficient because "the majority of alcohol-related death, disability and damage is attributable to moderate

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[20] The Guide to Community Preventive Services, *What Works: Preventing Excessive Alcohol Consumption*, https://www.thecommunityguide.org/sites/default/files/assets/What-Works-Factsheet-Alcohol.pdf.

[21] *Alcohol Facts and Statistics*, *supra* note 17.

[22] Centers for Disease Control and Prevention, *Fact Sheets – Underage Drinking*, https://www.cdc.gov/alcohol/fact-sheets/underage-drinking.htm.

[23] Traci L. Toomey & Alexander C. Wagenaar, *Policy Options for Prevention: The Case of Alcohol*, 20 J. PUB. HEALTH POL'Y 192, 192-93 (1999).

drinkers who engage in occasional risky drinking, not those who are dependent on alcohol."[24]

No single regulation by itself can do the job, and indeed, the best public health outcomes are associated with a policy environment that includes multiple regulatory mechanisms that complement and reinforce one another. The purpose of these regulations is not to eliminate drinking altogether, but instead to reduce *excessive* drinking and its attendant adverse consequences.[25]

Since the end of Prohibition, the states have been empowered through the Twenty-first Amendment to fashion regulatory tools that take account of the particular conditions within their jurisdictions and the needs of their citizens. Public health research supports the efficacy of many of these tools in helping to *moderate* alcohol consumption and mitigate the harmful effects of *excessive* consumption. These include restricting the outlets at which alcohol may be sold; limiting the days and hours of sale; increasing taxes on alcohol; setting minimum price floors; holding owners and/or servers at "on premise" establishments (such as restaurants and bars) liable for harms caused by excessive alcohol consumption (known as "dram-shop"

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[24] *Id.* at 192; Fred Martineau et al., *Population-level interventions to reduce alcohol-related harm: An overview of systematic reviews*, 57 PREV. MED. 278, 279 (2013).

[25] Terrel L. Rhodes, *Policy, Regulation, and Legislation*, *in* SOCIAL AND ECONOMIC CONTROL OF ALCOHOL: THE 21ST AMENDMENT IN THE 21ST CENTURY 79, 82-85 (Carole L. Jurkiewicz & Murphy J. Painter eds., 2008).

liability); and enhancing enforcement of laws aimed at cutting down on drinking and driving.[26]

Perhaps the most well-known regulation is the establishment of the minimum legal drinking age of 21. All states adopted such laws by 1984, when the federal government conditioned the receipt of transportation funding on raising the legal drinking age.[27] That single change in the law has been highly successful in reducing deaths and injuries.[28] Similarly, increasing the price of alcohol through the imposition of taxes has been shown to reduce consumption across all groups, including young people and heavy drinkers.[29] In fact, a

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[26] Toomey & Wagenaar, *supra* note 23, at 194-200; *Alcohol: No Ordinary Commodity—a summary of the second edition*, 105 ADDICTION 769, 772-73 (2010); Paul J. Gruenewald, *Regulating Availability: How Access to Alcohol Affects Drinking and Problems in Youth and Adults*, 34 ALCOHOL RESEARCH & HEALTH 248, 250 (2011); Andrew J. Treno, et al., *A Review of Alcohol and Other Drug Control Policy Research*, JOURNAL OF STUDIES ON ALCOHOL AND DRUGS 98, 100-01 (2014); Carla Alexia Campbell, et al., *The Effectiveness of Limiting Alcohol Outlet Density As a Means of Reducing Excessive Alcohol Consumption and Alcohol-Related Harms*, 37 AM. J. PREV. MED. 556 (2009); Veda Rammohan, *Effects of Dram Shop Liability and Enhanced Overservice Law Enforcement Initiatives on Excessive Alcohol Consumption and Related Harms*, 41 AM. J. PREV. MED. 334 (2011).

[27] Toomey & Wagenaar, *supra* note 23, at 201.

[28] *Id.*; Treno, et al., *supra* note 26, at 100.

[29] Toomey & Wagenaar, *supra* note 23, at 199; *Alcohol: No Ordinary Commodity*, *supra* note 26, at 772-73; Randy W. Elder et al., *The Effectiveness of Tax Policy Interventions for Reducing Excessive Alcohol Consumption and Related Harms*, 38 AM. J. PREV. MED. 217, 218 (2010).

ten percent increase in the price of alcohol yields a three to ten percent *decrease* in consumption.[30] Other policies that restrict the *availability* of alcohol are likewise potent tools for curbing misuse. Public health research has revealed that the greater the density of alcohol retailers in a community, the greater the consumption and the harms it can cause in those communities, including crime and violence.[31] Other studies have shown that when jurisdictions permit the sale of alcohol on Sundays after previously banning it, they experience an uptick in motor vehicle crashes, driving under the influence, and law enforcement interactions with intoxicated persons.[32]

There have not been any public health studies specifically evaluating the relationship between state residency requirements and alcohol-related harms. This is not surprising, since such studies are difficult and expensive to conduct. That said, the research described above is highly suggestive that durational residency requirements, which reduce the availability of alcohol and enhance retailer accountability, promote public health goals and help maintain the health and safety of communities.

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[30] Elder, et al., *supra* note 29, at 226.

[31] Toomey & Wagenaar, *supra* note 23, at 197; Gruenewald, *supra* note 26, at 250; Treno, et al., *supra* note 26, at 101.

[32] Jennifer Cook Middleton et al., *Effectiveness of Policies Maintaining or Restricting Days of Alcohol Sales on Excessive Alcohol Consumption and Related Harms*, 39 AM. J. PREV. MED. 575, 585-86 (2010).

D. Durational Residency Requirements Serve the Twin Goals of Restricting the Availability of Alcohol and Ensuring That Sellers Are Tied to the Communities in Which They Do Business.

The single most consistent finding in the public health research is that more availability of alcohol leads to more drinking, and more drinking leads to more negative health outcomes and associated social harms. Indeed, "[r]esearch indicates strongly that as alcohol becomes more available through commercial or social sources, consumption and alcohol-related problems rise."[33] State regulation has therefore naturally focused on limiting the number and type of retailers authorized to sell alcohol.

One of the ways in which Tennessee has chosen to nurture an orderly market in which liquor is regulated is through the durational residency requirement. That requirement ensures that sellers have a stake in the communities in which they do business. Recall that in the aftermath of Prohibition, those involved in designing the new state regulatory systems were determined to avoid re-introducing the "menace" that was the saloon,[34] with its out-of-state owners and their lack of regard for the welfare of the communities in which they peddled cheap alcohol. Tennessee's residency requirement means that retailers live and work in the state and thus their own well-being is at least somewhat bound up with that of their

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[33] *Alcohol: No Ordinary Commodity*, *supra* note 26, at 773.

[34] FOSDICK & SCOTT, *supra* note 11, at 10.

communities. Indeed, requiring two years of residency, rather than something nominal, like days or weeks, enhances the prospects that retailers are firmly anchored in the state and have meaningful communal relationships that matter to them. Such resident retailers have a greater incentive to comply with alcohol laws and adhere to responsible business practices than do non-resident retailers.

There is a substantial body of research demonstrating that retailers who adopt more scrupulous business practices play a significant role in helping to reduce alcohol-related harms. Such practices include training staff not to serve youth and intoxicated patrons; minimizing the marketing of alcohol, especially the use of advertisements that attract young adults; and refraining from offering happy hours, discount drinks, and drink promotions.[35] Retailers with a stake in the community are more likely to voluntarily abide by these types of sound practices than are retailers with no similar community connection.

Tennessee's durational residency requirement also curtails the availability of alcohol by preventing out-of-state chain stores, such as grocery stores, convenience stores, pharmacies, and gas stations, from selling alcohol. The evidence shows that these kinds of chain retailers contribute to an increase in availability in at least two ways. First, they tend to have extended hours of operation, making it easier for consumers to obtain alcohol when they want it. And second, the scale of their operations means they can sell alcohol more

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[35] Toomey & Wagenaar, *supra* note 23, at 197-200.

cheaply, such as through larger quantities and lower prices. By limiting the overall number of retailers, Tennessee's residency requirement ensures that the option to purchase liquor exists, but that the state's communities are not flooded with it.[36]

While public health researchers have not specifically assessed the impact of Tennessee's durational residency requirement on the incidence of alcohol-related harms within the state, they have taken stock of its total alcohol policy environment and concluded that it is one of the best in the country. In the study reporting these findings, the researchers explained that they measured each state's policy environment based on a survey of its composite alcohol laws. Tennessee ranked among the top three in the country. The researchers then compared each state's measurement against its rate of binge drinking. Tennessee again performed exceptionally well, with the

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[36] Data from 2017 shows that Tennessee has 552 "off-premise" retailers that are licensed to sell spirits, and 2,876 "on-premise" outlets that are licensed to do so. Among Tennessee's fellow "license" jurisdictions, four states (Alaska, Arkansas, Delaware, and Rhode Island) and the District of Columbia have fewer "off-premise" spirits outlets. Among all states, both "license" and "control," a total of 12 (Idaho, Montana, New Hampshire, Oregon, Utah, Vermont, West Virginia, and Wyoming, in addition to the four license states identified above) have fewer "off-premise" spirits outlets, as compared to Tennessee. The Beverage Information and Insights Group, BEER HANDBOOK 2018, 176-77. This suggests that Tennessee's durational residency requirement is playing the predictable and desirable role of limiting the availability of spirits within the state.

lowest rate of binge drinking in the country.[37] This is powerful evidence that Tennessee is doing something right.

E. Relaxing State Alcohol Controls Leads to More Drinking and More Social Harms.

Eliminating one or more regulations from a multi-faceted alcohol-control system, or attempting to substitute one regulation for another, often reduces the efficacy of the overall policy architecture. Advocates of deregulation typically argue that jettisoning various controls will benefit consumers through lower prices and greater availability (marketed as customer "convenience"). They ignore the considerable evidence that lower prices and greater availability are the drivers of excessive consumption and therefore that leaving them exclusively to market forces is a recipe for a public health disaster.

Similarly, courts that invalidate particular alcohol regulations sometimes justify their decisions in part by pointing to alternatives that are purportedly capable of accomplishing the same result, as the Sixth Circuit majority did in this case. *Byrd v. Tenn. Wine & Spirits Retailers Ass'n*, 883 F.3d 608, 625-26 (6th Cir. 2018); *see also Wal-Mart Stores, Inc. v. Tex. Alcoholic Bev. Comm'n*, 313 F. Supp.3d 751, 776-77 (W.D. Tex. 2018); *but see Costco Wholesale Corp. v. Maleng*, 522 F.3d 874 (9th Cir. 2008) (commenting that, "[t]he district court's suggestion that the State should serve its interest in

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[37] Timothy S. Naimi et al., *A New Scale of the U.S. Alcohol Policy Environment and Its Relationship to Binge Drinking*, 46 AM. J. PREV. MED. (2015).

some other way disparages the policy choices that Section 2 of the Twenty-first Amendment commits to the states").

However, public health researchers and advocates have found that the implementation of suitable alternatives is, at best, a steep climb. For one thing, state regulatory structures function as a system and, as with most systems, pulling out one piece tends to leave the whole more fragile and less effective. For another, adopting new, substitute regulations is a difficult and time-consuming undertaking that can easily be eclipsed by more pressing legislative or regulatory demands or fall prey to industry interests. Indeed, courts have sometimes pointed to excise taxes as a kind of panacea for promoting state interests in limiting excessive alcohol consumption, *see e.g.*, *Wal-Mart Stores, Inc.*, 313 F. Supp.3d at 776-77, but while there is strong evidence that excise taxes are quite effective, as a practical matter they are seldom imposed.[38] This reluctance likely stems from the general American aversion to taxes of any sort.[39] In fact, over time, the cost of alcohol has declined because alcohol taxes have not been increased to account for inflation and rising incomes; recently, costs have gone down even more owing to changes in federal tax law.[40]

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[38] Jurkiewicz & Painter, *supra* note 6, at 9; Toomey & Wagenaar, *supra* note 23, at 199; *Alcohol: No Ordinary Commodity*, *supra* note 26, at 772-73.

[39] Jurkiewicz & Painter, *supra* note 6, at 9.

[40] *Alcohol: No Ordinary Commodity*, *supra* note 26, at 773.

The alternative, hypothetical regulations proposed by the Sixth Circuit would almost certainly prove to be burdensome or expensive to administer (or both) and less effective than the straightforward residency requirement. The court concluded that Tennessee could accomplish its goals by requiring a retailer's general manager to be a state resident; by requiring both in-state and out-of-state retailers to post a substantial bond to obtain a license; by holding public meetings into each application for a license; or by creating an electronic database to monitor liquor retailers. *Byrd*, 883 F.3d at 625-26. From a public health perspective, none of these is well-tailored to the task of reducing alcohol-related harms.

Requiring a retailer's general manager to be a state resident falls short because the manager is not subject to the compliance requirements that the actual license-holder is, and the manager is just an employee, who lacks the decision-making authority of the owner.

Second, it's hard to imagine how the posting of a bond would incentivize retailers to engage in more conscientious business practices in the way that actual membership in the community does. The risk of losing some or all of a chunk of money is not the same as the risk of personal harm to one's community standing or harm to one's other interests that are tied to the overall health of the community. And a bond posting might lead chain retailers to dominate the market since they are likely to have the resources to post such a bond, whereas a smaller retailer might not; that in turn could increase the availability of alcohol for the reasons already discussed.

Finally, public meetings to obtain a license and the maintenance of electronic databases would impose substantial staffing and other costs on the state. And public meetings do not promise the same capacity to incentivize *ongoing* responsible business practices, beyond the showing made at the hearing itself. While an electronic database might provide a mechanism for continuing oversight, an entire additional regulatory structure would have to be built and enforcement capacity increased to make the database effective. In short, none of the Sixth Circuit's contemplated alternatives have the built-in capacity to accomplish what the simple, easy-to-implement residency requirement can accomplish.

When deregulation occurs—either through judicial invalidation or otherwise—it is extremely difficult to re-regulate. Deregulation, in turn, is associated with greater outlet density, longer hours of sale, and increased price competition, all of which promote consumption.[41] Deregulation is often pushed by chain retailers, and the experience of the state of Washington serves as a cautionary tale.

Before 2012, Washington controlled the sale of liquor through state-run outlets and the sale of wine was subject to various regulations. The national retailer Costco wanted the ability to sell these products to its customers and to do so at competitive prices. After it failed to get what it wanted through litigation and legislative lobbying, it financed a state-wide ballot initiative intended to deregulate the sale of wine and

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[41] Treno, et al., *supra* note 26, at 102; Gruenewald, *supra* note 26, at 249-51.

eliminate the state monopoly on the sale of liquor. By arguing that the state needed to modernize its alcohol laws and that customers would benefit from reduced prices and greater convenience in buying alcohol, Costco's gambit worked and Washington voters approved its initiative.[42]

As a result, state liquor stores were shuttered in favor of licensing private retailers. Because the law was written to benefit chain retailers by mandating that only those sellers with at least 10,000 square feet of space could obtain a license, the large outlets like Safeway, Kroger, and Wal-Mart, in addition to Costco, were able to dominate the market.[43]

The initiative dealt a blow to at least two post-Prohibition regulatory measures with a proven track record of success.

First, the initiative weakened the three-tier system of separate and distinct operations at the producer, wholesaler, and retailer levels by basically fusing the wholesale and retail functions for the large chain stores. These stores now have greater control over pricing, which they can use to stimulate sales.[44]

Second, the initiative substantially increased the number of outlets selling spirits. Washington went

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[42] Pamela S. Erickson, *Alcohol Deregulation by Ballot Measure in Washington State* (2014), http://www.healthyalcoholmarket.com/pdf/Alcohol_Deregulation_by_Ballot_Measure_in_Washington_State.pdf.

[43] *Id.*

[44] *Id.*

from 328 state and contract stores open a maximum of 73 hours a week, to approximately 1,415 stores open a maximum of 140 hours a week. This represented a five-fold increase in outlets.[45]

The dramatic rise in the number of outlets had indisputably increased the *availability* of liquor, a known factor associated with excessive consumption and its attendant social harms.[46] Indeed, an early study of the initiative's impact found that theft of liquor products had increased, as had emergency room visits related to alcohol, and the frequency of youth drinking.[47] Surveys of Washington residents since the passage of the initiative show that they have buyers' remorse and would not vote in favor of it today, knowing what they know now.[48]

Countries that have taken the deregulatory route have also experienced a significant negative impact on public health. A good example of this is the United Kingdom which, over the last five decades, has

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[45] *Id.*

[46] An early study assessing the initiative's impact found that the price of alcohol had not declined, but that was likely due to certain one-time taxes and fees that the measure had imposed on certain sellers. Whether prices will drop in the mid- to long-term remains to be seen. Erickson, *supra* note 42.

[47] Erickson, *supra* note 42.

[48] Meenakshi S. Subbaraman & William C. Kerr, *Opinions on the Privatization of Distilled-Spirits Sales in Washington State: Did Voters Change Their Minds?* 77 JOURNAL OF STUDIES ON ALCOHOL AND DRUGS 568-76 (2016), https://www.isad.com/doi/full/10.15288/jsad.2016.77.568.

substantially deregulated the sale of alcohol.[49] Alcohol there is now cheaper and more widely available than it was before deregulation.[50] Four large grocery stores dominate the market and they have been permitted to sell alcohol at less than cost to attract customers and increase sales.[51] The results have been notably damaging on public health.[52] For instance, in the ten-year period between 2004 and 2014, the United Kingdom experienced a 13 percent increase in the number of deaths related to alcohol consumption, and almost double the number of hospital admissions related to alcohol.[53]

In sum, deregulation frequently has as its objective and its result making alcohol more widely available. But public health research conclusively demonstrates that greater availability leads to greater consumption, which in turn leads to greater health problems and social ills. From the highly deregulated era preceding Prohibition, to the modern-day examples of the United Kingdom and the state of Washington, curtailing state regulation imposes significant human and financial costs. Invalidating Tennessee's durational residency requirement poses a real danger of weakening the

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[49] Pamela S. Erickson, *The Dangers of Alcohol Deregulation: The UK Experience, 2016 Update*, http://healthyalcoholmarket.com/pdf/UKUpdate2016.pdf.

[50] *Id.*

[51] *Id.*

[52] *Id.*

[53] *Id.*

state's overall regulatory scheme and rendering it more vulnerable to those factors—attenuated retailer relationships with the communities they serve and the increased availability of alcohol—that are positively correlated with greater consumption and attendant social harms.

CONCLUSION

The Sixth Circuit's decision did not take account of the public health benefits that durational residency requirements can bestow. Concerns about public health and welfare are integral to this country's historical experience with alcohol and the ways in which the federal and state governments have sought to control it. Therefore, no review of the Constitutional question presented in this case is complete without considering the public health dimension of alcohol regulation.

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Respectfully submitted,

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APPENDIX

APPENDIX

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Names of Additional *Amici* . . . . . App. 1

APPENDIX—NAMES OF ADDITIONAL *AMICI*

Addiction Policy Forum
Alcohol Justice
American Public Health Association (APHA)
APHA – Alcohol, Tobacco and Other Drugs Section
California Alcohol Policy Alliance
ChangeLab Solutions
Community Anti-Drug Coalitions of America (CADCA)
Drug Free America Foundation, Inc.
Facing Addiction with NCADD
Florida Coalition Alliance
Hillsborough County Anti-Drug Alliance
Institute for Behavior and Health
Institute for Public Strategies
Project Extra Mile
Public Health Advocacy Institute
Michigan Alcohol Policy Promoting Health and Safety
Michigan Council on Alcohol Problems
NAADAC – the Association of Addiction Professionals
National Association for Children of Addiction
Needham Public Health Division
New Futures
Save Our Society from Drugs
Smart Approaches to Marijuana (SAM)
South Dakota Alcohol Policy Alliance
Student Assistance Services Corporation
Students Against Destructive Decisions (SADD)
Tampa Alcohol Coalition
TASC, Inc. (Illinois)
Vital Strategies
WestCare Foundation